

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0025403</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Carlton At The Lake</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>725 W. Montrose Ave</u> <u>Chicago</u> <u>60613</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(773) 929-1700</u> Fax # <u>(773) 929-3066</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																									
IDPA ID Number: <u>363075919001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>07/31/80</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Carlton At The Lake# 0025403 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>244</u>	Skilled (SNF)	<u>244</u>	<u>89,304</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>244</u>	TOTALS	<u>244</u>	<u>89,304</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>65,195</u>	<u>4,274</u>	<u>6,125</u>	<u>75,594</u>	8
9	SNF/PED					9
10	ICF	<u>8,325</u>	<u>72</u>		<u>8,397</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>73,520</u>	<u>4,346</u>	<u>6,125</u>	<u>83,991</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.05%

D. How many bed-hold days during this year were paid by Public Aid?

62 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/01/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/01/80 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 24 and days of care provided 3,447Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Carlton At The Lake

0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	340,164	110,993	13,478	464,635		464,635	3,844	468,479			1
2	Food Purchase		492,550		492,550	(72,468)	420,082	(253)	419,829			2
3	Housekeeping		49,529	295,853	345,382		345,382	11,944	357,326			3
4	Laundry		38,899	126,794	165,693		165,693		165,693			4
5	Heat and Other Utilities			231,022	231,022		231,022	3,484	234,506			5
6	Maintenance	59,483	17,848	127,435	204,766		204,766	(8,913)	195,853			6
7	Other (specify):*											7
8	TOTAL General Services	399,647	709,819	794,582	1,904,048	(72,468)	1,831,580	10,106	1,841,686			8
	B. Health Care and Programs											
9	Medical Director			32,400	32,400		32,400		32,400			9
10	Nursing and Medical Records	2,757,096	210,301	25,609	2,993,006		2,993,006		2,993,006			10
10a	Therapy	103,118	895	19,468	123,481		123,481		123,481			10a
11	Activities	121,538	44,480	7,508	173,526		173,526		173,526			11
12	Social Services	171,955		4,331	176,286		176,286		176,286			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,153,707	255,676	89,316	3,498,699		3,498,699		3,498,699			16
	C. General Administration											
17	Administrative	531,886		665,195	1,197,081		1,197,081	(657,135)	539,946			17
18	Directors Fees											18
19	Professional Services			565,047	565,047		565,047	(442,471)	122,576			19
20	Dues, Fees, Subscriptions & Promotions			72,591	72,591		72,591	(53,383)	19,208			20
21	Clerical & General Office Expenses	78,992	2,064	307,682	388,738		388,738	(67,684)	321,054			21
22	Employee Benefits & Payroll Taxes			750,115	750,115	72,468	822,583	(141,822)	680,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,600	4,600		4,600	839	5,439			24
25	Other Admin. Staff Transportation			5,191	5,191		5,191	(617)	4,574			25
26	Insurance-Prop.Liab.Malpractice			274,446	274,446		274,446	861	275,307			26
27	Other (specify):*							48,248	48,248			27
28	TOTAL General Administration	610,878	2,064	2,644,867	3,257,809	72,468	3,330,277	(1,313,164)	2,017,113			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,164,232	967,559	3,528,765	8,660,556		8,660,556	(1,303,058)	7,357,498			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Carlton At The Lake

#0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			210,906	210,906		210,906	10,304	221,210			30
31	Amortization of Pre-Op. & Org.							171	171			31
32	Interest			359,826	359,826		359,826	(308,467)	51,359			32
33	Real Estate Taxes			283,519	283,519		283,519	8,379	291,898			33
34	Rent-Facility & Grounds			1,335,900	1,335,900		1,335,900	(1,335,900)				34
35	Rent-Equipment & Vehicles			76,470	76,470		76,470	(32,511)	43,959			35
36	Other (specify):*			15,262	15,262		15,262	(8,418)	6,844			36
37	TOTAL Ownership			2,281,883	2,281,883		2,281,883	(1,666,442)	615,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		239,191	607,504	846,695		846,695		846,695			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,956	133,956		133,956		133,956			42
43	Other (specify):*	55,600			55,600		55,600	(55,600)				43
44	TOTAL Special Cost Centers	55,600	239,191	741,460	1,036,251		1,036,251	(55,600)	980,651			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,219,832	1,206,750	6,552,108	11,978,690		11,978,690	(3,025,100)	8,953,590			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,814)	30		9
10	Interest and Other Investment Income	(349,528)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(253)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(312)	21		18
19	Entertainment				19
20	Contributions	(36,800)	20		20
21	Owner or Key-Man Insurance	(141,822)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(208,699)	21		24
25	Fund Raising, Advertising and Promotional	(13,366)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(166)	20		28
29	Other-Attach Schedule	(521,545)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,308,306)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,716,794)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,716,794)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,025,100)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Carlton At The Lake

0025403

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES			Amount	Reference
1	Auto Fee		\$ (2,170)	32 1
2	Officers Life Insurance - Bldg Co		(58,286)	32 2
3	Loss on Sale of Assets		(8,418)	35 3
4	Parking Fee Income		(420)	06 4
5	Misc. Income		(360)	23 5
6	Bank Charges		(21,510)	23 6
7	IL Council - COPI Dues		(4,335)	20 7
8	Franchise Tax		(110)	23 8
9	Management Fees - Bernard Cohen		(12,800)	17 9
10	Nonallowable Management Fees - Inc		(27,300)	17 10
11	Amortization - Bldg Co		(16,047)	36 11
12	Accounting - Bldg Co		(4,866)	19 12
13	Trait Fees - Bldg Co		(250)	23 13
14	State Replacement Tax - Bldg Co		(11,929)	21 14
15	Marketing Auto Expense		(617)	25 15
16	Nonallowable Auto Lease		(35,323)	35 16
17	Nonallowable Professional Fee		(4,800)	19 17
18	Collection Fees		(075)	23 18
19	Collection Expense		(113,714)	19 19
20	Nonallowable Legal		(4,145)	19 20
21	Capitalized R&M		(12,760)	06 21
22	Non-Allowable Interest		(54,999)	32 22
23	Nonallowable Salary		(69,822)	17 23
24	Marketing Salary		(55,600)	43 24
25				25
26				26
27				27
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99				99
100				100
101	Total		(521,548)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlton At The Lake

0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary						3,844						3,844	1
2	Food Purchase	(253)											(253)	2
3	Housekeeping						11,944						11,944	3
4	Laundry													4
5	Heat and Other Utilities						3,484						3,484	5
6	Maintenance	(13,188)					4,275						(8,913)	6
7	Other (specify):*													7
8	TOTAL General Services	(13,441)					23,547						10,106	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative	(119,022)		(506,711)	4,167	1,631	(37,200)						(657,135)	17
18	Directors Fees													18
19	Professional Services	(126,516)	4,860	1,316	151	953	(323,235)						(442,471)	19
20	Fees, Subscriptions & Promotions	(54,667)				423	861						(53,383)	20
21	Clerical & General Office Expenses	(244,074)	12,179	3,772		4,843	155,596						(67,684)	21
22	Employee Benefits & Payroll Taxes	(192,072)	50,250										(141,822)	22
23	Inservice Training & Education													23
24	Travel and Seminar						839						839	24
25	Other Admin. Staff Transportation	(617)											(617)	25
26	Insurance-Prop.Liab.Malpractice						861						861	26
27	Other (specify):*			2,844	329	10,531	34,544						48,248	27
28	TOTAL General Administration	(736,968)	67,289	(498,779)	4,647	18,381	(167,734)						(1,313,164)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(750,409)	67,289	(498,779)	4,647	18,381	(144,187)						(1,303,058)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(35,814)	32,185				13,933						10,304	30
31	Amortization of Pre-Op. & Org.						171						171	31
32	Interest	(406,697)	80,868				17,362						(308,467)	32
33	Real Estate Taxes						8,379						8,379	33
34	Rent-Facility & Grounds		(1,335,900)										(1,335,900)	34
35	Rent-Equipment & Vehicles	(35,321)					2,810						(32,511)	35
36	Other (specify):*	(24,465)	16,047										(8,418)	36
37	TOTAL Ownership	(502,297)	(1,206,800)				42,655						(1,666,442)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(55,600)											(55,600)	43
44	TOTAL Special Cost Centers	(55,600)											(55,600)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,308,306)	(1,139,511)	(498,779)	4,647	18,381	(101,532)						(3,025,100)	45

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,335,900	Carlton Associates, Ltd	100.00%	\$	\$ (1,335,900)	1
2	V	32 Interest Income	269,971	Carlton Associates, Ltd	100.00%		(269,971)	2
3	V	32 Interest Expense		Carlton Associates, Ltd	100.00%	350,839	350,839	3
4	V	22 Officers Life Insurance		Carlton Associates, Ltd	100.00%	50,250	50,250	4
5	V	19 Accounting		Carlton Associates, Ltd	100.00%	4,860	4,860	5
6	V	21 Trust Fees		Carlton Associates, Ltd	100.00%	250	250	6
7	V	30 Depreciation		Carlton Associates, Ltd	100.00%	32,185	32,185	7
8	V	36 Amortization		Carlton Associates, Ltd	100.00%	16,047	16,047	8
9	V	21 State Replacement Tax		Carlton Associates, Ltd	100.00%	11,929	11,929	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,605,871			\$ 466,360	\$ * (1,139,511)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 25,004	\$ 25,004	15
16	V	19 PROFESSIONAL FEES				1,316	1,316	16
17	V	21 OFFICE				3,772	3,772	17
18	V	27 PAYROLL TAXES				2,844	2,844	18
19	V							19
20	V							20
21	V	17 MARVIN NEEDLE-CONS. FEES				36,296	36,296	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V	17 MANAGEMENT FEES	568,011				(568,011)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 568,011			\$ 69,232	\$ * (498,779)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 4,167	\$ 4,167	15
16	V	19 PROFESSIONAL FEES				151	151	16
17	V	27 PAYROLL TAXES				329	329	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 4,647	\$ * 4,647	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 49,615	\$ 49,615	15
16	V	19 PROFESSIONAL FEES				953	953	16
17	V	20 FEES, SUBSCRIPTIONS				423	423	17
18	V	21 CLERICAL AND GENERAL				4,843	4,843	18
19	V	27 GEN ADMIN.- EMP. BEN.				10,531	10,531	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	47,984				(47,984)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 47,984			\$ 66,365	\$ * 18,381	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY	\$	ITEX COMPANY	100.00%	\$ 3,844	\$ 3,844
16	V	3 HOUSEKEEPING				11,944	11,944
17	V	5 UTILITIES				3,484	3,484
18	V	6 REPAIRS AND MAINT.				4,275	4,275
19	V	19 PROFESSIONAL FEES				8,205	8,205
20	V	20 FEES, SUBSCRIPTIONS				861	861
21	V	21 CLERICAL AND GENERAL				23,454	23,454
22	V	24 EDUCATION/SEMINARS				839	839
23	V	26 INSURANCE				861	861
24	V	27 EMPLOYEE BENEFITS				370	370
25	V	30 DEPRECIATION				13,933	13,933
26	V	31 AMORTIZATION				171	171
27	V	32 INTEREST				17,362	17,362
28	V	33 REAL ESTATE TAXES				8,379	8,379
29	V	35 EQUIPMENT RENTAL				2,810	2,810
30	V						
31	V						
32	V	21 CLERICAL SALARIES				132,142	132,142
33	V	27 GEN ADMIN. - EMP. BEN.				34,174	34,174
34	V						
35	V	19 HOME OFFICE	331,440				(331,440)
36	V	17 MANAGEMENT FEES	37,200				(37,200)
37	V						
38	V						
39	Total		\$ 368,640			\$ 267,108	\$ * (101,532)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake # 0025403 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	Owner	Management	20.00%	See Attached	2.00	3.08%	Shaymark	\$ 4,167	17-7	1
2	Jack Rajchenbach	Relative	Management		See Attached	18.00	27.69%	Salary, Fees	118,604	17-1, 17-7	2
3	Daniel Cohen	Owner	Social Services	6.67%	None	40.00	100.00%	Salary	44,072	12-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 166,843		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization JLR MANAGEMENT CORP.Street Address 6633 NORTH LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 76,400	\$ 76,400	18	\$ 25,004	1
2	19 PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	4,020		18	1,316	2
3	21 OFFICE	AVG. HOURS WORKED	55	10	11,524	9,614	18	3,772	3
4	27 PAYROLL TAXES	AVG. HOURS WORKED	55	10	8,689		18	2,844	4
5									5
6									6
7	17 MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296		40	36,296	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 136,929	\$ 86,014		\$ 69,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization SHAYMARK MANAGEMENT CORP.Street Address 6633 NORTH LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	5	\$ 100,000	\$ 100,000	2	\$ 4,167	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	5	3,632	2	151		2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	48	5	7,883	2	329		3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 111,515	\$ 100,000		\$ 4,647	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CAREPATH HEALTH NETWORKStreet Address 6633 N LINCOLN AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (888) 707-6700Fax Number (847) 679-2150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMINISTRATIVE	CARE PATH FEES	227,090	9	\$ 234,811	\$ 234,811	47,984	\$ 49,615	1
2	19 PROFESSIONAL FEES	CARE PATH FEES	227,090	9	4,511		47,984	953	2
3	20 FEES, SUBSCRIPTIONS	CARE PATH FEES	227,090	9	2,000		47,984	423	3
4	21 CLERICAL AND GENERAL	CARE PATH FEES	227,090	9	22,918		47,984	4,843	4
5	27 GEN ADMIN.- EMP. BEN.	CARE PATH FEES	227,090	9	49,841		47,984	10,531	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 314,081	\$ 234,811		\$ 66,365	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ITEX COMPANYStreet Address 6633 N. LINCOLN AVE.City / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 DIETARY	AVAILABLE BED DAYS	465,918	5	\$ 20,387	\$	87,840	\$ 3,844	1
2	3 HOUSEKEEPING	AVAILABLE BED DAYS	465,918	5	63,352		87,840	11,944	2
3	5 UTILITIES	AVAILABLE BED DAYS	465,918	5	18,482		87,840	3,484	3
4	6 REPAIRS AND MAINT.	AVAILABLE BED DAYS	465,918	5	22,673		87,840	4,275	4
5	19 PROFESSIONAL FEES	AVAILABLE BED DAYS	465,918	5	43,523		87,840	8,205	5
6	20 FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	465,918	5	4,565		87,840	861	6
7	21 CLERICAL AND GENERAL	AVAILABLE BED DAYS	465,918	5	124,405		87,840	23,454	7
8	24 EDUCATION/SEMINARS	AVAILABLE BED DAYS	465,918	5	4,449		87,840	839	8
9	26 INSURANCE	AVAILABLE BED DAYS	465,918	5	4,565		87,840	861	9
10	27 EMPLOYEE BENEFITS	AVAILABLE BED DAYS	465,918	5	1,965		87,840	370	10
11	30 DEPRECIATION	AVAILABLE BED DAYS	465,918	5	73,905		87,840	13,933	11
12	31 AMORTIZATION	AVAILABLE BED DAYS	465,918	5	908		87,840	171	12
13	32 INTEREST	AVAILABLE BED DAYS	465,918	5	92,090		87,840	17,362	13
14	33 REAL ESTATE TAXES	AVAILABLE BED DAYS	465,918	5	44,443		87,840	8,379	14
15	35 EQUIPMENT RENTAL	AVAILABLE BED DAYS	465,918	5	14,907		87,840	2,810	15
16									16
17									17
18	21 CLERICAL SALARIES	DIRECT ALLOCATION		6	784,794	784,794		132,142	18
19	27 GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	202,958			34,174	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,522,371	\$ 784,794		\$ 267,108	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake# 0025403

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake # 0025403 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Working Capital			\$	3,299,425		8.7700	\$ 239,889	1
2	First Bank and Trust		X	Auto Loan				1,840			317	2
3	First Priority Leasing		X	Elevator	\$176.00	05/08/02	8,785	4,928	04/28/07		408	3
4	Graybar Financial		X	Nurse Call System	\$3,702.00	12/27/00	150,212		09/27/04	8.5000	1,146	4
5	See Supplemental Schedule							1,383,496			350,839	5
	Working Capital											
6	LaSalle Bank		X	Line of Credit				1,750,000			55,065	6
7	Shareholders/LaSalle Bank		X	Working Capital				550,000			54,999	7
8	See Supplemental Schedule										(31,804)	8
9	TOTAL Facility Related				\$3,878.00		\$ 158,997	\$ 6,989,689			\$ 670,859	9
	B. Non-Facility Related*											
10	Interest Income		X								(349,528)	10
11	Interest Income (Bldg Co)		X								(269,971)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			\$ (619,499)	14
15	TOTALS (line 9+line14)						\$ 158,997	\$ 6,989,689			\$ 51,360	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	LaSalle Bank		X	Mortgage			\$	\$ 1,383,496			\$ 350,839	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term							1,383,496			350,839	7							
	Working Capital																		
8	Insurance Financing		X				\$	\$			\$ 5,833	8							
9	Non-Allowable Interest										(54,999)	9							
10	Allocate ITEX		X	Working Capital							17,362	10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital										(31,804)	14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Carlton At The Lake**# **0025403**

Report Period Beginning:

01/01/04

Ending:

12/31/04**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	384,805		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	334,390		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(50,415)		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	342,312		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	291,897		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	382,952	8		
	2000	353,230	9		
	2001	362,417	10		
	2002	366,480	11		
	2003	326,011	12		
Accrual: \$326,011 X 1.05 = \$342,312					
Allocate from ITEX \$8,379					
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlton At The Lake COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025403

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-16-300-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>80,936.85</u>	\$ <u>80,936.85</u>
2. <u>14-16-300-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>76,797.48</u>	\$ <u>76,797.48</u>
3. <u>14-16-300-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>78,855.71</u>	\$ <u>78,855.71</u>
4. <u>14-16-300-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>626.12</u>	\$ <u>626.12</u>
5. <u>14-16-300-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>9,939.44</u>	\$ <u>9,939.44</u>
6. <u>14-16-300-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>78,855.71</u>	\$ <u>78,855.71</u>
7. <u>10-35-312-022-0000</u>	<u>Home Office</u>	\$ <u>46,549.68</u>	\$ <u>8,389.91</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>372,560.99</u></u>	\$ <u><u>334,401.22</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlton At The Lake COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025403

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 B. General Construction Type:
 Exterior Brick
 Frame
 Number of Stories 4

C. Does the Operating Entity?
 (a) Own the Facility
 (X) (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (X) (a) Own the Equipment
 (X) (b) Rent equipment from a Related Organization.
 (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES NO (X)

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 171
 4. Dates Incurred:

Nature of Costs: Allocate ITEX

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1993	\$ 153,000	1
2					2
3	TOTALS			\$ 153,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carlton At The Lake

0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various	1980	105,427		20	-			105,426
10	Various	1981	5,718		20	-			5,718
11	Various	1982	2,618		20	-			2,618
12	Various	1983	19,855		20	48	(48)		19,696
13	Various	1984	34,158		20	-			34,155
14	Various	1985	72,850		20	66	66		72,843
15	Various	1986	24,885		20	1,191	1,191		23,207
16	Various	1988	6,456		20	141	141		5,924
17	Various	1989	61,761		20	3,043	3,043		48,816
18	Various	1990	71,334		20	3,567	3,567		51,891
19	Various	1991	165,717		20	8,286	8,286		100,549
20	Various	1992	228,201		20	9,200	9,200		149,411
21	Various	1993	40,886		20	513	513		30,766
22	Various	1994	51,259		20	2,730	2,730		31,364
23	Various	1995	92,308		20	4,616	4,616		45,120
24	Various	1996	58,573		20	3,180	3,180		27,191
25	Various	1997	204,822		20	10,242	10,242		94,666
26	Various	1998	26,362		20	1,319	1,319		9,096
27	Various	1999	27,003		20	1,350	1,350		7,428
28	Various	2000	408,272		20	20,417	20,417		98,021
29						-			-
30						-			-
31						-			-
32						-			-
33						-			-
34						-			-
35						-			-
36						-			-

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,255,206	32,185		32,185		366,104	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		371,113	8,922		12,076	3,154	136,954	68
69	Financial Statement Depreciation			210,906			(210,906)		69
70	TOTAL (lines 4 thru 69)		\$ 3,334,784	\$ 252,013		\$ 114,170	\$ (137,939)	\$ 1,466,964	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Carlton At The Lake

0025403

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,560,730	\$ 252,013		\$ 125,558	\$ (126,455)	\$ 1,505,484	1
2	Cooling Twr New	2002	3,791		20	379	379	979	2
3	Heater	2002	972		20	97	97	292	3
4	Faucet & Sink Line	2002	945		20	95	95	284	4
5	Water Pump	2002	554		20	55	55	152	5
6	Repair Alarm	2002	1,195		20	120	120	329	6
7	Air Handling Unit	2002	1,047		20	105	105	297	7
8	Freezer Repair	2002	1,482		20	148	148	408	8
9	Ejector Pump	2002	725		20	73	73	205	9
10	Brick Pavers	2002	650		20	65	65	173	10
11	Hot Water Pump	2002	2,620		20	262	262	677	11
12	Tamper Switch	2002	715		20	72	72	173	12
13	Exhaust Fan Repair	2002	4,929		20	493	493	1,150	13
14	Security Lighting	2002	1,750		20	250	250	542	14
15	Light Fixtures	2002	643		20	64	64	193	15
16	Tiles	2002	524		20	52	52	144	16
17	Cove Base	2002	823		20	82	82	226	17
18	Ceiling Tiles	2002	529		20	53	53	145	18
19	Motor For Cooling Tower	2002	985		20	99	99	254	19
20	Plumbing	2002	597		20	60	60	139	20
21	Ceiling Paint	2002	580		20	58	58	121	21
22	Elevator Repair	2002	1,638		20	82	82	225	22
23	Install Vinyl Tile In Elevators	2002	1,250		20	125	125	344	23
24	Elevator Repair	2002	693		20	69	69	179	24
25	Elevator Repair	2002	1,738		20	87	87	217	25
26	Elevator Repair	2002	693		20	35	35	90	26
27	Elevator Repair	2002	697		20	35	35	76	27
28	Elevator Repair	2002	965		20	97	97	209	28
29	Elevator Repl.Valve	2002	9,369		20	468	468	1,015	29
30	Circuit Breakers / Electric Outlets	2003	6,750		20	675	675	1,294	30
31	Camera And Cabling	2003	1,037		20	207	207	363	31
32	Camera / Cabeling / And Monitor	2003	1,440		20	288	288	504	32
33	Alarm System Control Box	2003	733		20	147	147	257	33
34	TOTAL (lines 1 thru 33)		\$ 3,613,789	\$ 252,013		\$ 130,555	\$ (121,458)	\$ 1,517,140	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

12/31/04

****Improvement type must be detailed in order for the cost report to be considered complete.**

12/31/04

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12F, Carried Forward		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
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14								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12G, Carried Forward		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12I, Carried Forward		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,686,085	\$ 252,013		\$ 137,207	\$ (114,807)	\$ 1,525,650	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	244	1993		\$ 1,255,206	\$ 32,185		\$ 32,185	\$	\$ 366,104
5									
6									
7									
8									
Improvement Type**									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
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56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)			\$ 1,255,206	\$ 32,185		\$ 32,185	\$	\$ 366,104	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocation - ITEX/A.K. Care		1993		\$ 302,414	\$ 7,754	35	\$ 8,640	\$ 886	\$ 100,084	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - ITEX/A.K. Care		1993		38,052	459	20	1,903	1,444	22,273	9
10	Allocation - ITEX/A.K. Care		1994		20,439	532		1,022	490	10,507	10
11	Allocation - ITEX/A.K. Care		1995		3,483	9	20	174	165	1,602	11
12	Allocation - ITEX/A.K. Care		1996		197	-	20	10	(10)	89	12
13	Allocation - ITEX/A.K. Care		1997		5,876	151		294	143	2,203	13
14	Allocation - ITEX/A.K. Care		1999		652	17	20	33	16	196	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 371,113	\$ 8,922		\$ 12,076	\$ 3,134	\$ 136,954	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 664,836	\$ 2,233	\$ 70,495	\$ 68,262	10	\$ 389,484	71
72	Current Year Purchases	69,496	2,779	8,257	5,478	10	8,257	72
73	Fully Depreciated Assets	629,885				10	629,885	73
74								74
75	TOTALS	\$ 1,364,217	\$ 5,012	\$ 78,752	\$ 73,740		\$ 1,027,626	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2003 Honda Accord	2003	\$ 26,262	\$	\$ 5,252	\$ 5,252	5	\$ 10,505	76
77										77
78										78
79										79
80	TOTALS			\$ 26,262	\$	\$ 5,252	\$ 5,252		\$ 10,505	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,229,564	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 257,025	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,211	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (35,814)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,563,781	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Remodeling	\$ 466,185	92
93			93
94			94
95		\$ 466,185	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 43,959

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 279,954	\$		\$ 279,954	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			12,754			12,754	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			314,796			314,796	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				142,222		142,222	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): See Supplemental						96,969		96,969	13
14	TOTAL			\$		\$ 607,504	\$ 239,191		\$ 846,695	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,250	\$ 99,309	1
2	Cash-Patient Deposits	132,045	132,045	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,979,953	2,979,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	196,001	196,001	6
7	Other Prepaid Expenses	9,420	9,420	7
8	Accounts Receivable (owners or related parties)	6,404,875	8,728,763	8
9	Other(specify): See Attached Schedule	204,472	204,472	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,931,016	\$ 12,349,963	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		153,000	13
14	Buildings, at Historical Cost		1,255,206	14
15	Leasehold Improvements, at Historical Cost	1,082,292	1,082,292	15
16	Equipment, at Historical Cost	1,841,739	1,963,739	16
17	Accumulated Depreciation (book methods)	(2,315,158)	(2,803,262)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	34,219	68,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(19,391)	(19,391)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	829,201	829,201	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,452,902	\$ 2,529,010	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,383,918	\$ 14,878,973	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,795,011	\$ 1,795,011	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	137,335	137,335	28
29	Short-Term Notes Payable	612,246	612,246	29
30	Accrued Salaries Payable	109,072	109,072	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,054	25,054	31
32	Accrued Real Estate Taxes(Sch.IX-B)	342,312	342,312	32
33	Accrued Interest Payable	527	527	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	18,266	18,266	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,039,823	\$ 3,039,823	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,993,947	4,993,947	39
40	Mortgage Payable		1,383,496	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,993,947	\$ 6,377,443	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,033,770	\$ 9,417,266	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,350,148	\$ 5,461,707	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,383,918	\$ 14,878,973	48

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*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,966,855	1
2	Restatements (describe):		2
3	State Replacement Tax	(25,075)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,941,780	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	408,368	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 408,368	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,350,148	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Carlton At The Lake

0025403

Report Period Beginning: 01/01/04

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VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,222,149	1
2	Discounts and Allowances for all Levels	(913,520)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,308,629	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,201,605	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,201,605	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	402	15
16	Rental of Facility Space		16
17	Sale of Drugs	294,885	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,931	19
20	Radiology and X-Ray		20
21	Other Medical Services	207,206	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 526,424	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	349,600	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 349,600	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	800	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 800	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,387,058	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,904,048	31
32	Health Care	3,498,699	32
33	General Administration	3,257,809	33
	B. Capital Expense		
34	Ownership	2,281,883	34
	C. Ancillary Expense		
35	Special Cost Centers	902,295	35
36	Provider Participation Fee	133,956	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,978,690	40
41	Income before Income Taxes (line 30 minus line 40)**	408,368	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 408,368	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,216	\$ 95,117	\$ 42.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	46,962	54,538	1,234,864	22.64	3
4	Licensed Practical Nurses	14,646	16,900	304,408	18.01	4
5	Nurse Aides & Orderlies	96,292	109,478	936,591	8.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,836	10,491	103,118	9.83	8
9	Activity Director	1,714	1,843	31,486	17.08	9
10	Activity Assistants	10,498	11,278	90,052	7.98	10
11	Social Service Workers	9,509	10,224	171,955	16.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,072	2,296	39,224	17.08	14
15	Cook Helpers/Assistants	36,407	39,189	300,940	7.68	15
16	Dishwashers					16
17	Maintenance Workers	4,261	4,807	59,483	12.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,160	2,160	236,824	109.64	20
21	Assistant Administrator	7,281	7,891	131,590	16.68	21
22	Other Administrative	2,160	2,160	163,472	75.68	22
23	Office Manager					23
24	Clerical	3,845	4,620	78,992	17.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	13,766	16,058	186,116	11.59	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,027	3,255	55,600	17.08	33
34	TOTAL (lines 1 - 33)	265,356	299,404	\$ 4,219,832 *	\$ 14.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	284	\$ 13,478	01-03	35
36	Medical Director	Monthly	32,400	09-03	36
37	Medical Records Consultant	Monthly	8,197	10-03	37
38	Nurse Consultant	295	9,612	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	26	1,368	10a-03	40
41	Occupational Therapy Consultant	345	18,100	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	143	7,508	11-03	44
45	Social Service Consultant	83	4,331	12-03	45
46	Other(specify)				46
47	Dental Director	Monthly	4,200	10-03	47
48	Utilization Review	Monthly	3,600	10-03	48
49	TOTAL (lines 35 - 48)	1,176	\$ 102,794		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Rosemary Betz	Administrator	0	\$ 236,824	Workers' Compensation Insurance	\$ 54,639		IDPH License Fee	\$ 1,734
Bila Cieckli	Asst Admin	0	35,036	Unemployment Compensation Insurance	48,396		Advertising: Employee Recruitment	1,868
Jack Rajchenbach	Executive Dir	0	93,600	FICA Taxes	304,300		Health Care Worker Background Check	1,580
Christopher Betz	Asst Admin	0	22,427	Employee Health Insurance	163,182		(Indicate # of checks performed <u>158</u>)	
Marvin Needle	Asst Admin	0	74,127	Employee Meals	72,468		Dues and Subscriptions	11,153
Nonallowable Salary (Adjusted Out on Page 5)			69,872	Illinois Municipal Retirement Fund (IMRF)*			Licenses and Permits	1,589
				Head Tax	6,668		Allocate Carepath	423
				401K	6,988		Allocate ITEX	861
				Pension	23,360			
				Holiday Expense	760			
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 531,886					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)	\$ 680,761		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,208
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Carepath - Network Fees			\$ 47,984	Description	Line #	Amount	Description	Amount
Management Fees - JLR Management			568,011				Out-of-State Travel	\$
Management Fees - Bernard Cohen & Associates (Adj on P. 5a)			12,000					
See Supplemental Schedule			37,200				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 665,195					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Personnel Planners	Unemployment Consult		\$ 2,358					
Healthcare Horizons (Adjusted Out on Page 5a)			4,800					
Giftrap	Computer Consultant		3,509					
Medi.com	Computer Support		14					
SLS	Computer Service		125					
PSD Solutions	Computer Consultant		11,306					
A.K. Care	Bookkeeping		331,440					
Achieve Accreditation	Joint Commission Cslt		8,583				Seminar Expense	4,600
See Attached Schedule	Legal		72,183				Allocate ITEX	839
FR&R	Accounting		18,018					
Commitment Consulting (Adjusted Out on Page 5a)			112,711					
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 5,439
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 565,047					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council - \$9,819
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,967 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 133,956
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 72,468 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.